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Organisational Space for Partnership and Sustainability: Lessons from the Implementation of the National Dementia Strategy for England

Abstract

National policy initiatives are faced with challenges in their partnership development and sustainability. The National Dementia Strategy for England (DH 2009a) recommended Dementia Adviser and Peer Support Network services and 40 demonstration sites were established. In this paper we report on the national evaluation of these demonstration sites, with specific reference to aspects of organisational development.

The research used a mixed-methods design with three main strands: (i) activity and outcome monitoring; (ii) organisational surveys and collaborative discussion; (iii) in-depth case studies in eight of the 40 sites. This paper focuses primarily on three rounds of organisational surveys distributed to all 40 demonstration sites over a period of 21 months and interviews in the case studies.

Data identifies the significance of infrastructure within immediate services as well as the position of services within the external infrastructure of the wider health and social care landscape. Partnership - both internally and externally - was key to establishing and sustaining services that flourished. When working well, Dementia Advisers and Peer Support Networks acted as a link between services and people with dementia at the same time as filling gaps in existing support, providing information, advice and interpersonal support that was tailored to individual needs and circumstances.

In conclusion, to achieve the full potential and sustainability of services requires them to be in an organisational space that allows them to work in partnership and collaboration with other services, and that values their distinct knowledge of their communities.

Key Words: Dementia, strategy, peer support, dementia advisers, organisational development, sustainability

What is known about this topic:

1. The National Dementia Strategy for England (DH 2009a) recommended the new services of Dementia Advisers and Peer Support Networks and established 40 demonstration sites for one-year.
2. It is particularly complex to implement multi-organisational services.
3. Partnership and leadership are important aspects of developing new services.

What this paper adds:

1. The pressure for sustainability as a service within one year can overshadow partnership development and user engagement.
2. For the demonstration sites, the global recession added unparalleled challenges to the sustainability of the services.
3. New services need to attend to their organisational space within a health and social care economy.

Organisational Space for Partnership and Sustainability: Lessons from the Implementation of the National Dementia Strategy for England

Introduction

Policy implementation frequently triggers new service initiatives, leading to complex interactions between new and pre-existing services. This is particularly challenging when working across services and has implications for workforce roles and the sustainability of new services. This paper addresses these debates through the example of the implementation of 40 demonstrator sites of Dementia Advisors (DA) and Peer Support Networks (PSN) (recommended in the National Dementia Strategy for England, Department of Health, DH, 2009a). The National Dementia Strategy for England (DH 2009a) recommended peer support networks (PSN) and Dementia Advisers (DA) as important forms of service provision and established 40 demonstration sites (18 PSN sites and 22 DA sites) (DH 2009b). The 40 demonstration sites were chosen by the DH through a competitive application process and were located within a wide range of organisational structures, with a range of lead and partner organisations involved (National Health Service, Local Authorities, Community and Voluntary Sector services).

Sustainability and partnership

Sustainability and partnership are key concepts in the organisational activity surrounding the implementation and development of services, which we explore here in relation to several international studies.

Based on a longitudinal evaluation of a primary Health Care Service in Australia, Buykx *et al.* (2012) define sustainability in terms of the ability of services to provide quality care alongside organisational capacity to adapt to changing environments. They identify four key success factors in sustainable organisational development: community engagement; strong leadership and committed champions with a vision; strategic relationship building and health service linkages. These factors, Buykx *et al.* (2012) suggest, are held within a tension between internal changes (such as workforce) and external changes (including the political and health service environment). Similarly, drawing on an evaluation of an English pilot of 28 clinical services with three year follow-up, Martin *et al.* (2012) explore the pathways to medium-term sustainability of services. Key influences on sustainability were: enthusiasm and effort, inter-professional collaboration and multiple forms of leadership (Davies & Edwards 2009). In a Dutch-based cross-sectional study involving 106 professionals from 21 innovative community care programmes, Cramm *et al.* (2013) also link sustainability with strong partnerships - and for partnerships to function well, there is a need for leadership (as highlighted too by Jones & Barry 2011), efficiency, administration and non-financial resources. This, they suggest, leads in turn to “partnership synergy” with people working together in implementing and sustaining innovative solutions which in turn leads to sustainability of those innovations.

Multi-organisational partnerships are particularly complex, requiring involvement of multiple leaders (Chrislip & Larson 1994) and an understanding of each other’s roles. Britten *et al.* (2006), in a study of a peer support breastfeeding initiative in Scotland, found that when lay health workers are (mis)perceived as a replacement for professional staff there is the potential for duplication of effort and undermining of each other’s roles and position

which can weaken the work of the service (as reported too by Ziersch 2000, and Ward *et al.* 2009). Lester *et al.* (2008) undertook interviews with 91 voluntary and community sector leads and commissioners to explore partnership between the health and voluntary sectors in Early Psychosis Intervention Services in England - they found that more holistic services included a shared agenda in priorities and principles and recognition that skills within each sector would complement each other, whilst barriers to multi-sector working included differences in organisational culture, and available resources.

Partnership with service users in establishing and developing health and social care services is also key (Beresford & Branfield 2006, Hernandez *et al.* 2010). In a review of a consultation process that took place alongside the implementation of a local dementia strategy in Scotland, McCabe and Bradley (2012) found that people with dementia were able to meaningfully contribute to the development of strategy. Including the views of people with dementia gained support for the strategy and aided its implementation.

In this paper, we report on those aspects of the national evaluation of PSN and DAs in the 40 demonstration sites which focus on the service and organisational mechanisms that were significant in their implementation (addressing aims 1 and 2 below). We identify what was effective as well as the barriers and challenges for health, social care and voluntary sector organisations seeking to support people living with dementia. In discussing the complex organisational issues we consider: boundary work, partnerships, the tension between national policy and local need and the significance of organisational space.

The key aims of the research were:

1. Describing the range of demonstration site services, including organisational structure, governance and operational mechanisms.
2. Assessing the new service models in relation to their influence on the wellbeing of people with dementia and carers, contribution to the aims of the National Dementia Strategy for England and their place within the wider health and social care economy.
3. Identifying ways in which DAs and PSNs contributed to the wellbeing and resilience of people with dementia and carers, with a focus on accessibility of services, involvement and information and support for making choices and independence.

Methods

A mixed methods research design with three strands of data collection and analysis was used to capture the breadth of activity that was taking place in the 40 DA and PSN demonstrator sites, and the depth of views and experiences of people with dementia, their carers, staff, volunteers and other stakeholders. A mixed methods paradigm brings both strengths and limitations to a research project. Broadly, it can strengthen the quality of the research by combining the strengths of each approach and mitigating the internal limitations of each (Johnson & Onwuegbuzie 2004). For example, whilst surveys tend to gather descriptive data, we were able to use interviews to explore points in more details, and reflect some points from interviews back in subsequent surveys to stimulate reflection. Some data were collected across all of the demonstrator sites, and some were collected from a sample of eight of the demonstrator sites that formed case study sites and were selected because they represented the diversity of all of the sites. Data was collected between October 2010 and March 2012.

Ethical approval was obtained from the Social Care Research Ethics Committee (Ref: 10/IEC08/13). Full details of the research methodology and methods are available in the full report (Clarke *et al.* 2013).

Strand one focussed on activity and outcome monitoring, including quantitative data representing the numbers and demographics of people accessing the sites and wellbeing and quality of life of people with dementia and carers, measured using the Adult Social Care Outcomes Toolkit (ASCOT, Office for National Statistics 2010).

Strand two focussed on organisational surveys and collaborative discussions, including postal survey data concerning organisational structure and development and structured discussion with demonstrator site leads and commissioners during national workshops.

Strand three focussed on in-depth case studies at eight of the sites, including qualitative interviews with people with dementia, carers, staff, volunteers and other key stakeholders.

There are two sources of data which underpin the focus of this paper on the organisational conditions and mechanisms through which support for people with dementia and their carers was provided: postal survey data collected from all 40 demonstration sites which provide evidence for the organisational structure and development of the sites (strand two) and qualitative data collected as part of the in-depth case study site interviews (strand three). We also report on the information on how many people were accessing sites (strand one): these data were collected through all of the sites reporting the number of people accessing services for the first full week of each of eight months over an 18 month period.

Organisational Survey Data Collection

Three rounds of postal organisational surveys were distributed to the service lead for all 40 sites and returned by post or e-mail. It is important to note the global fiscal context of recession which became apparent during the first (DH funded) year of service implementation - subsequent economy savings in the UK public services meant that it was particularly difficult for services to be sustained and there were periods of exceptional uncertainty about the future for the sites and this influenced response rates (see Table 1).

[Insert Table 1 around here]

The first survey asked 10 questions about the areas described in Box 1. The data from this survey were also used to sample the eight case study sites for more in-depth data collection by interview. The content and format of this first survey was agreed with representatives of the pilot study sites during a national network meeting prior to circulation, five months post-commencement of the national pilot study.

[Insert Box 1 around here]

The second survey, 13 months after the first, asked a set of questions which were more in-depth in relation to the 'individuality' each of the sites, the purpose of which was to gathered information on how site activity had evolved and developed, for example purpose and scope of services and changes in organisational structure (including those sites that had ceased activity). There was a specific focus in the second survey on commissioning activity. As part of the mixed-methods approach to data collection and analysis, an excerpt from a qualitative interview with a commissioner at one of the DA sites was presented and sites were asked to indicate whether they agreed or disagreed with this statement: '*what started*

off as a very small pot of money has mushroomed into all sorts of other benefits and spin offs'.

The third round of organisational surveys was distributed 7 months later (20 months after the first survey) to all sites that were believed to be still active. The revised 10 questions elicited responses which provided an updated overview of developments, specifically the purpose of site activity. In this survey, the responses to questions about overall purpose of services from surveys that had been returned in the second round were extracted and presented to each site, with staff asked to comment on if and how this had changed or evolved.

Organisational Survey Data Analysis

The information from all of the site surveys was collated using EXCEL, resulting in comparison of answers to questions within and across the sites. In order for patterns within the open-ended qualitative survey data to be established, the information was prepared and imported into NVivo9, a Computer Aided Qualitative Data Analysis Software (CAQDAS) tool. This ensured that themes from the site survey data could be analysed in the light of the thematic framework which emerged from the analysis of over 200 in-depth qualitative interviews with people with dementia, carers, staff and stakeholders.

Whilst the focus within this paper is on the organisational surveys, we also draw upon the qualitative data from the in-depth case study interviews. Interviewees who took part in that aspect of the research were selected through a sampling framework which, in addition to input from key site staff ensured a range of views and opinions. Data analysis was a five-stage process in which a thematic framework was developed and verified using the tools of

NVivo9. Initially, a selection of 25 transcripts, representing the range of people interviewed across all of the case study sites, was used to create a coding framework. This coding framework was further developed by applying it to a further 70 transcripts, including 18 transcripts coded by the wider research team. Once the framework had been established, the emerging themes were developed, leading to a process of modelling the data using the modelling tools in NVivo. Finally, using the query tools in NVivo, the models were verified using the entire data set.

Findings

Organisational Characteristics

This section reports on some of the characteristics of the services and those who accessed them. There was considerable variability of organisational structure in the services but four are described as examples in Table 2, with data drawn from the organisational surveys (selected as representative of the breadth of purpose and ways of working of the sites).

[Insert Table 2 around here]

The main goals roles and purposes of sites specified by site staff were: Information advice and signposting; Enabling access to support and services; Crisis prevention and early intervention; Maintaining independence, wellbeing and quality of life; Enabling participation and engagement; Reaching specific communities, for example BME communities. Box 2 presents data from Strand 1 to illustrate levels of service use.

[Insert Box 2 around here]

The role of DAs included enabling access to a wide range of support, including social groups, financial and legal support and support that enabled people to remain independent for longer. Within their role of co-ordinating information about services and signposting, in addition, DAs had a role in working in partnership and collaboration with other local organisations, ensuring that their role in signposting to other services was followed up by those services. DAs also had a role in supporting immediate networks and communities surrounding people with dementia and carers, making use of community resources and pre-existing social networks.

In relation to PSNs, some groups were activity based while others had more of a focus on dementia and discussion (some with this dual purpose), some groups were for people with dementia or carers on their own and some jointly. Positive aspects of PSNs reported in Strand 3 interviews included socialising, feeling valued and developing interests within the context of interpersonal interaction with people who had common experiences of living with dementia. The facilitator's role within PSNs included recruitment, processing referrals and publicity, ensuring the smooth running of groups and, at times, providing information, advice and one-to-one support.

For services to flourish, infrastructure surrounding the services was essential, both internal infrastructure (what went on within the immediate services) and external infrastructure (the ways in which the immediate services interacted with a range of organisations and individuals outside of the immediate activity of the services). We consider three interlinked areas: clarity of purpose, visibility and partnership/collaboration.

Clarity of purpose

Clarity around the remit of DA and PSN services was linked with the extent to which people with dementia and carers accessed support:

But it's actually getting people through the door ... Maybe they don't understand what a peer support group is. (Carer who had accessed PSN site, Interview).

The following example from a PSN site illustrates the need to communicate to potential service users the purpose and scope of the services in relation to reaching the local BME community:

Key learning about the local [BME] population, is helping to 'shape' the tactics used to engage with this community and raise awareness of dementia. For example, the launch of carers support groups did not 'take off' for this particular community, so the project is now concentrating on building relationships and trust within the community, alongside existing local BME groups to raise awareness. (PSN, site survey round 2).

Externally, there was a need for clarity in the role and purpose of DA and PSN services in their relationship to pre-existing services. Examples were given by external agencies of confusion relating to lack of clarity:

It's confused local policy and practice in a very big way. There was clarity previously, now there isn't clarity – there is confusion, there's a reduction in referrals to all the services. ... I think people now don't know what to do. I think they're more confused now than they were before the service existed. Because they have introduced ambiguity and blurred the role boundaries. (Alan, Area manager from voluntary sector organisation that provided support for people with dementia and carers alongside a DA service, interview).

Further insight into the need for clarity lies in what was said by staff and stakeholders in the in-depth case study sites about resolving barriers and challenges. For example, the positive impact of communicating the support offered by services through "success stories" of people who had benefited from services, including this example of a person with dementia becoming involved at an organisational level:

[He] came to some of our groups, built his confidence. Now attends lots of our groups. He's on our project board. He's coming to our memory drop-in sessions to give talks to other people with dementia, to tell them about his journey. And to use that as an example to inspire other people to come to structured peer support. (Bev, PSN facilitator, interview).

Visibility

The visibility of new services to other services was essential for referral processes and the accessibility and partnerships of the services, and the demonstrator sites used many approaches to enhance their visibility.

A display stand was on show in each surgery for one week at a time and members of each team participating attended the surgeries during one week (and) visiting local GP services and attending clinician meetings. (PSN service, site survey round 3).

Key channels through which the support was accessed included: local voluntary sector organisations, for example local support groups, as well as direct referrals from professionals. For some, not having to go through statutory services to access support was significant and community links were key:

We have referrals from all sources. So statutory services, health and local authority, other care agencies, hairdressers, chiropodist, [John] in the coffee shop... (Staff from DA site, Interview).

Word of mouth within pre-existing social networks, and through evidence from people who had previously been supported was also significant in people engaging with services, and closely linked to the visibility of services. This is of particular importance in reaching BME communities:

I feel it is one of the most important services available, but I think it will take a long time, like everything, to build up a network.....That, to a large extent, will come from word of mouth of people who've experienced it, rather than it being thrust upon them. A GP suggesting "I think, perhaps, you should see somebody" is not the way I feel it's going... (Volunteer from PSN site, Interview).

Lack of visibility amongst other providers of support to people with dementia and carers was a significant hindrance to the service flourishing:

‘There is not a ready source of referrals to the project, as it is not embedded within current mental health provision’ (PSN service, site survey round 3).

Partnership and collaborative working

Partnership and collaboration were essential to the external infrastructure surrounding the services, including with pre-existing services and with engagement with people with dementia and carers in shaping services. The services were working with and alongside many other organisations across all three sectors (as illustrated in Table 2).

The experiences of organisational partnerships were varied. When working well, this included a positive knock-on effect within the wider health and social care landscape, with partnerships adding to both clarity and visibility, internally and externally:

The service has also enabled great partnership working across all agencies in the statutory, voluntary and private sector in ensuring that dementia care is at the forefront of service provision. (DA site survey round 1).

However, other sites referred to partnership as a hindrance or delay to the implementation of services: ‘[we are hindered by a] *lack of good will towards partnership working*’ (PSN site survey 2). Others referred to a process of partnership and collaboration which, although it started with uncertainty about whether the service was in direct competition with pre-existing services, ended in a realisation of the additional benefit that it provided:

[We] can now identify that the service is an addition and a benefit to people with dementia and their carer’s and families and not as a replacement for their services. (DA, site survey round 2).

Effective partnership also enabled the innovative ways of supporting people with dementia and carers to be adopted by other services and organisations in the locality: ‘*Due to the*

nature of the partnership, other successful ventures have been established for people with dementia - the funding and joint working have enabled innovation' (PSN Site Survey 2).

The following quote outlines from the perspective of someone who had accessed support from the service the positive impact of the service “tying everything together”: evidence of partnership between a demonstration site service and pre-existing services having a positive impact:

We've never... Previously, you know... Experience of anything like this. And it just... Just that knowledge that to go the GP is not... You don't get the information that you need – you can come here and you can get some information on how the condition is going to progress. You can get information on any benefits or anything that you might be entitled to. Any activities that we've got. That information – I wouldn't know where to find it and it's not one place anywhere else. There's just so much here but... And then we've come to the meeting and you might have some of the nurses from the memory clinic who my dad sees for his 6-monthly reviews up there. So, you know, it ties everything in together, really. (Nancy, Carer who had accessed PSN support group services, Interview).

Achieving such benefits from the services was supported by the willingness, in most of the demonstration site areas, of the wider health and social care organisations to work hard at developing their partnerships, as described by a commissioner below:

And we spent a lot of time trying to maintain and build that relationship and it works really well now. So, you know... But I think you have to respect that any pilot that comes in and is doing bits of other people's work, or what they may have been doing at that time, will immediately be seen as a threat. So it's very important in how that is handled. (Val, Commissioner DA site, Interview).

Data collected from the in-depth case study sites also provided insight into the important role of people with dementia and carers in the aspects of the organisations such as designing and developing the services:

I think the most important thing is that the agenda for what happens in these groups needs to be very much driven by and generated by the people who are involved because that is the whole point. (Chris, Commissioner PSN site, Interview).

Partnership with service users

In-depth case study data provides examples of ways in which people with dementia and carers were involved within the organisational aspects of demonstration sites. These included: public consultation prior to establishing the services; carers of people with dementia sitting on steering groups/project boards and/or project reference groups; involvement in the development of local dementia strategies (often developed prior to or alongside the demonstration sites). At an operational level, people with dementia and carers were influential through their involvement in training professionals and raising awareness about the services. Peer support itself was referred to as a means of service user involvement, as was the role of their views and needs in shaping the support provided, for example specific interest groups. Barriers and challenges relating to involvement of people with dementia and carers were also identified, including ways of meaningfully involving people with dementia (not just carers) and people balancing involvement in services amidst already pressured lives.

Discussion

Critique of the study

Postal questionnaires do not always yield a high quality of volume of data but the mixed methods design of this research resulted in an ability to interpret this data alongside interview and other forms of data. The research team also established a close relationship with the leads for the services and were known personally to all 40 which enhanced the

response rate and quality of data. As outlined by Salisbury *et al.* (2010), the complex nature of carrying out policy evaluations within an increasingly diverse health and social care landscape is not unique to this research. The most significant event that was outside anyone's control, however, was the global economic downturn, the change of UK Government, and the austerity measures. These occurred midway through the first year of operating for the sites and although no funding was withdrawn from the sites themselves and there was no change in dementia policy, concerns about staffing reductions and inability to sustain the services preoccupied the services and coloured engagement with the research and the content of interviews and site surveys. The individual sites experienced a period of being unsettled and staff had a high level of uncertainty and anxiety about the future for sites and for their own employment. Sites had been supported by a national Implementation Team for the National Dementia Strategy with a network of regional leads. This was removed around 18 months after the demonstration sites commenced and changed the dynamic between being national policy led and informed and being local needs led.

Partnerships and boundary work

The complex tensions identified in the internal and external infrastructure of the DA and PSN services reflects Buykx *et al.*'s (2012) work on the interactions between internal and external changes. These internal and external dimensions shaped the experiences and ambitions of services as they sought to establish themselves, find an organisational space in the local health and social care economy, and become sustainable. In this discussion, we consider partnerships and boundary work and the extent to which services needed to

balance national policy with local need. This leads to a discussion around the extent to which change brought about by the implementation of the services was superficial or was a deep, lasting change.

Echoing Cramm *et al.*'s (2013) work which links sustainability and partnership, a crucial aspect of the way in which the DA and PSN services developed was in attending to partnerships with other agencies, services and professions. Typically this was formalised through a steering group but much of the experience of partnership working was characterised by the need to identify and occupy a 'space' in service provision that complemented, and did not overlap, with pre-existing services. Whilst this was the focus in the earlier stages of establishing the services, it was rapidly overshadowed by a focus on seeking continuity of provision despite local and national policy changes (not least public sector restrictions as response to the global recession) and consequent operational changes such as changing role and personnel. At times, differences in organisational culture, identified by Lester *et al.* (2008) as a barrier to partnership working, influenced the extent to which partnerships were effective. Enhancing the acceptability of a new service and reducing role or service conflict can be helped by ensuring that established organisations have some ownership of the new service (e.g. Ward *et al.* 2009) – the importance of locally determined service need.

Achieving sustainability of pilot projects requires interpersonal interaction on many levels (Martin *et al.* 2012). The experiences of partnerships were very varied, and were the source of diverse and sometimes very strong views in different demonstrator sites and by different stakeholders. In some areas, the demonstrator site services were welcomed and all parties seemed to recognise that they met a previously unmet need. In other areas, the

demonstrator site services were regarded with some concern by other stakeholders as potentially competitive resulting in unnecessary duplication of provision. The interaction between stakeholders was complex as a result of the involvement of multiple organisations and, consequently, multiple leaders – thus echoing Chrislip and Larson’s (1994) work which identified a need for the acknowledgement of the involvement of leaders within all organisations in a partnership.

A strong relationship with established services and organisations also allows for strong communication and support between all bodies. There is the potential for professional support for staff and volunteers in new roles from established services, though this takes time to establish (Doherty & Coetzee 2005) and requires an understanding of the role so that it is not seen as a threat (Haour-Knipe *et al.* 1999). More evident in this research is the communications from the DAs and PSN coordinators to other services as they put in place that part of their work that was raising awareness about dementia and educating and influencing those in generic care roles about being person-centred and orientated to the needs of people with dementia.

Whilst Reed *et al.* (2005) suggested that providing a specialist service may mean that more generic services actually step back from the issue and allow the specialist services to take on this responsibility (and in so doing possibly becoming deskilled), this is a muted message in this data which suggests that services welcomed and benefited from the presence of such particular focus on dementia. Indeed, specialist services are all the more important when working with those who are ‘hard to reach’. Achieving the full potential of these services requires them to be in an organisational space that allows them to work in partnership and

collaboration with other services, and that values their distinct knowledge of their communities.

National policy-local need

There is a recurring tension evident in the data between local specificity of service provision in response to perceived local need and ideas of universal needs that can be instigated by national policy. This impacted on:

- the process of identifying the demonstrator sites in the first instance (being locally determined responses to a national strategy but approved for funding as a demonstrator site at a national level);
- the initiation of the services (with a variety of degrees of integration and acceptance into pre-existing services);
- the continuation and sustainability of the service (such that despite unchanging local need, national policy implementation imperatives resulted in perceived premature threat to the on-going viability of the services).

A key issue, then, concerns whether the service developments are driven by national policy or by local drivers (including service and professional drivers). This may lead to variability and vulnerability as services are exposed to changing local contexts, set diverse goals and targets, and exposed to changing national policy. Where national policy captured emerging but patchy local developments in peer support networks and dementia advice provision and promoted them into being more mainstreamed in the consciousness of dementia services, this role of national policy also left the demonstrator sites in a vulnerable situation because

they could be seen as nationally imposed rather than driven by perceived local need and so potentially somewhat estranged from other local services. The interplay between these local and national dynamics gave rise to concerns about local sustainability.

Deep change versus superficial change

Intersecting with this local-national dynamic is the tension between an agenda that drives superficial change and one that drives deep change (Carr & Clarke 2010). In the former, superficial change arises classically from a cycle of 'new' projects with limited building on previous work or acknowledgement of achievements and limited longevity (Martin *et al.* 2012). Projects have short timescales and minimal project cohesiveness, they are not necessarily needs driven but are responsive to proposals and so are fixed rather than evolutionary, and exit strategies are planned rather than there being a focus on sustainability and a long term view (Carr & Clarke 2010). The need to 'prove' themselves within a short time frame can result in a drive for publicity about successes and therefore for 'quick wins'. There is evidence of this approach in the data collected in this research but also recognition of, for example, the need for time for people with dementia to have confidence and trust in staff and services before they fully engage. Others spoke, for example, of learning that the physical location of meetings was important and the need to work with communities to identify suitable locations. Whilst the demonstrator sites provided an excellent opportunity to explore the provision of different services, there was also a counter-pressure in the imperative to prove themselves in order to aim for further funding and sustainability. There is a risk that where the latter dominates, new services are able to do little more than tinker around the edges of pre-existing services.

More fundamental reviews of health and service provision arise from changes that promote deep change (Carr & Clarke 2010). This more permanent learning takes place when there are mechanisms and strategies for knowledge to be exchanged in organisations, when steps are taken to avoid a loss of learning when it is located with individual posts or individual people, when interagency partnerships develop to progress learning and there is movement out of the 'comfort zone' (just doing things the way we always have and adhering to the familiar). In this way, activity is seen as evolutionary and knowledge building (from successes and failures) and the mainstreaming and sustainability of activities are integral from the outset.

Organisational Space

So to what extent have the DA and PSN services in the demonstrator sites achieved deep change and where have they needed to focus on the imperatives which may lead to more superficial change? The answer to this comes back to whether the DA role and the PSN services occupy an organisational 'space'. The services in the demonstrator services were able to engage with people with dementia and families in a way that potentially met a 'needs space' (Clarke *et al.* 2013) but for them to interlink this needs space with an organisational space is akin to being a bridge between social and organisational contexts, something that is a core element of the lay health worker role (Ungar *et al.* 2004, Racz & Lacko 2008). We see this in, for example, the way in which the services and their staff work within a community, using the resources of that community (its volunteers, public venues and social networks) for identifying and supporting families living with dementia.

However, where services have struggled sometimes to find an organisational space to work in and with, difficulties with partnerships with other services are manifest. To some extent

this is an inherent aspect of any new service and any new role, and indeed staff in the demonstrator sites were aware of this and attended to their relationship with other services (assisted by strategy boards and commissioners). As Ward *et al.* (2009) recommends, enhancing the acceptability of a new service and reducing role or service conflict can be helped by ensuring that established organisations have some ownership of the new service, emphasising further the importance of locally determined service need.

Conclusion

Achieving the full potential of services requires them to be in an organisational space that allows them to work in partnership and collaboration with other services, and that values their distinct knowledge of their communities. In relation to the implementation of the PSN and DA services, this research demonstrates that less attention was given to securing this 'organisational space' than was afforded the identification of a 'needs space' such that although there was evidence of identifying and meeting previously unmet need, at times, the lack of organisational space compromised partnership working and sustainability. It is crucial, therefore, that attention is given to organisational issues in seeking to implement policy-driven initiatives.

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